J. Provider Remittance Advice (RA) Codes

Section J.1 lists the Explanation of Benefit (EOB) and Adjustment Reason Codes that may appear on a Provider Remittance Advice (RA) for paid, denied, or adjusted claims.

J.1 Explanation of Benefit (EOB) Codes

EOB Code	EOB Description	Adjustment Reason Code
0201	INVALID PAY-TO PROVIDER NUMBER	125
0203	RECIPIENT I.D. NUMBER MISSING	16
0206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT	16
0208	PREGNANCY INDICATOR INVALID	45
0210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	125
0211	INVALID REFILL INDICATOR VALUE	16
0212	MISSING PRESCRIPTION NUMBER	16
0213	DATE PRESCRIBED IS MISSING	B17
0214	DATE PRESCRIBED IS INVALID	B17
0215	DATE DISPENSED IS MISSING	16
0216	DATE DISPENSED IS INVALID	16
0217	MISSING DRUG CODE	16
0218	INVALID DRUG CODE	16
0219	QUANTITY DISPENSED IS MISSING	16
0220	QUANTITY DISPENSED IS INVALID	16
0221	MISSING DAYS SUPPLY	16
0222	ESTIMATED DAYS SUPPLY INVALID	45
0223	MISSING DIAGNOSIS INDICATOR	16
0224	DIAGNOSIS TREATMENT INDICATOR INVALID	16
0225	REFERRING PROVIDER - INVALID FORMAT	16
0226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER	16
0227	THIRD PARTY PAYMENT AMOUNT INVALID	16
0233	UNITS OF SERVICE MISSING	16
0234	PROCEDURE CODE MISSING	16
0235	PROCEDURE CODE NOT IN VALID FORMAT	16
0239	DETAIL TO DATE OF SERVICE IS MISSING	16
0240	THE DETAIL TO" DATE IS INVALID "	16
0242	SECONDARY DIAGNOSIS CODE INVALID	47
0243	MISSING MEDICARE PAID DATE	17
0244	THIRD DIAGNOSIS CODE INVALID	47
0246	FOURTH DIAGNOSIS CODE INVALID	47
0247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	16

Deleted: ~~Explanation of Payments (EOP)~~

Added: Remittance Advice Codes (RA)

Deleted: ~~and J2~~

Deleted: ~~Section J.3 lists…into the system.~~

Deleted: ~~Claim Adjustment Reason…Advice Remark Codes~~

Added: Explanation of Benefit (EOB) Codes

Added: Adjustment Reason Codes

EOB Code	EOB Description	Adjustment Reason Code
0248	PLACE OF SERVICE IS MISSING OR BLANK	129
0249	PLACE OF SERVICE IS INVALID	129
0250	CLAIM HAS NO DETAILS	16
0251	FIRST MODIFIER INVALID FOR DATE OF SERVICE	4
0252	SECOND MODIFIER INVALID FOR DATE OF SERVICE	4
0253	THIRD MODIFIER INVALID FOR DATE OF SERVICE	4
0258	MISSING DIAGNOSIS CODE	16
0260	UNITS OF SERVICE NOT IN VALID FORMAT	16
0261	MISSING TOOTH NUMBER	16
0262	INVALID TOOTH NUMBER	16
0263	INVALID TOOTH SURFACE	16
0264	DETAIL FROM DATE OF SERVICE IS MISSING	16
0265	DETAIL FROM DATE OF SERVICE IS INVALID	16
0266	MISSING TOOTH SURFACE	16
0268	BILLED AMOUNT INVALID	16
0269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT	16
0270	MISSING TOTAL CLAIM CHARGE	16
0271	INVALID TOTAL CLAIM CHARGE	16
0272	PRIMARY DIAGNOSIS CODE INVALID	47
0273	TYPE OF BILL MISSING	16
0274	TYPE OF BILL CODE INVALID	16
0275	ADMIT DATE MISSING	16
0276	ADMIT DATE INVALID	16
0277	INVALID ADMISSION HOUR	16
0278	ADMIT TYPE MISSING	129
0279	INVALID TYPE OF ADMISSION	16
0280	PATIENT STATUS IS MISSING	129
0281	PATIENT STATUS IS INVALID	129
0282	MISSING COVERED DAYS	16
0283	COVERED DAYS INVALID	16
0284	PRIMARY CONDITION CODE INVALID	16
0285	SECOND CONDITON CODE INVALID	16
0286	THIRD CONDITION CODE INVALID	16
0287	FOURTH CONDITION CODE INVALID	16
0288	FIFTH CONDITION CODE INVALID	16
0289	SIXTH CONDITION CODE INVALID	16
0290	SEVENTH CONDITION CODE INVALID	16
0295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	16
0296	DATE FOR PRIMARY OCCURRENCE CODE INVALID	16
0297	DATE FOR SECOND OCCURRENCE CODE MISSING	16
0298	DATE FOR SECOND OCCURRENCE CODE INVALID	16
0299	DATE FOR THIRD OCCURRENCE CODE MISSING	16
0300	DATE FOR THIRD OCCURRENCE CODE INVALID	16
0301	DATE FOR FOURTH OCCURRENCE CODE MISSING	16
0302	DATE FOR FOURTH OCCURRENCE CODE INVALID	16
0339	REVENUE CODE IS MISSING	16

EOB Code	EOB Description	Adjustment Reason Code
0340	REVENUE CODE IS INVALID	16
0350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.	16
0355	FIFTH DIAGNOSIS CODE INVALID	47
0356	SIXTH DIAGNOSIS CODE INVALID	47
0357	SEVENTH DIAGNOSIS CODE INVALID	47
0358	EIGHTH DIAGNOSIS CODE INVALID	47
0359	NINTH DIAGNOSIS CODE INVALID	47
0360	ADMITTING DIAGNOSIS MISSING	47
0361	ADMITTING DIAGNOSIS CODE INVALID	47
0364	PRINCIPAL ICD9 PROCEDURE DATE MISSING	16
0365	PRINCIPAL ICD9 PROCEDURE DATE INVALID	16
0367	FIRST OTHER ICD9 PROCEDURE DATE MISSING	16
0368	FIRST OTHER ICD9 PROCEDURE DATE INVALID	16
0370	SECOND OTHER ICD9 PROCEDURE DATE MISSING	16
0371	SECOND OTHER ICD9 PROCEDURE DATE INVALID	16
0373	THIRD OTHER ICD9 PROCEDURE DATE MISSING	16
0374	THIRD OTHER ICD9 PROCEDURE DATE INVALID	16
0376	FOURTH OTHER ICD9 PROCEDURE DATE MISSING	16
0377	FOURTH OTHER ICD9 PROCEDURE DATE INVALID	16
0379	FIFTH OTHER ICD9 PROCEDURE DATE MISSING	16
0380	FIFTH OTHER ICD9 PROCEDURE DATE INVALID	16
0381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING	16
0395	HEADER STATEMENT COVERS PERIOD FROM" DATE MISSING "	16
0396	HEADER STATEMENT COVERS PERIOD FROM" DATE INVALID "	16
0397	HEADER STMT COVERS PERIOD THROUGH" DATE MISSING "	16
0398	STATEMENT COVERS PERIOD THROUGH" DATE INVALID "	16
0400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	16
0411	DATE FOR FIFTH OCCURRENCE CODE MISSING	16
0412	DATE FOR FIFTH OCCURRENCE CODE INVALID	16
0413	DATE FOR SIXTH OCCURRENCE CODE MISSING	16
0414	DATE FOR SIXTH OCCURRENCE CODE INVALID	16
0415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	16
0416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	16
0417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	16
0418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	16
0433	MEDICARE DEDUCTIBLE AMOUNT INVALID	2
0434	MEDICARE COINSURANCE AMOUNT INVALID	2
0436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	62
0450	INVALID QUADRANT	11
0450	INVALID QUADRANT	
0455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	16

EOB Code	EOB Description	Adjustment Reason Code
0456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	16
0457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	16
0458	THE DIAGNOSIS CODE IN SEQUENCE 10-24 IS IN AN INVALID FORMAT	47
0465	DATE FOR OCCURRENCE CODE 9-24 MISSING	16
0466	DATE FOR OCCURRENCE CODE 9-24 INVALID	16
0471	CONDITION CODE 8-24 INVALID	16
0474	ICD9 PROCEDURE 7-24 OR DATE MISSING	16
0475	ICD9 PROCEDURE 7-24 DATE INVALID	16
0500	DATE PRESCRIBED AFTER BILLING DATE	125
0502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	45
0503	DATE DISPENSED AFTER BILLING DATE	110
0505	NO PAYMENT MADE-TPL IS MORE THAN THE ALLOWED AMOUNT.	30
0507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	16
0508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	16
0512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29
0513	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION	16
0514	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV	16
0519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE	110
0526	DETAIL DATES NOT WITHIN HEADER DATES	16
0527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	16
0529	SURGERY DATE CANNOT BE PRIOR TO ADMIT DATE	129
0530	SURGERY DATE CANNOT BE OUTSIDE DATE OF SERVICE	129
0537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE	125
0555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29
0556	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29
0570	TOTAL DAYS LESS THAN COVERED DAYS	16
0571	SURGICAL PROCEDURE MISSING	16
0573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN	16
0574	SERVICE DATES ARE NOT IN SAME MONTH	16
0575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	16
0589	ADJUSTMENT HAS AUTO DENIAL	45
0595	MANUALLY SUSPEND FOR REVIEW	45
0596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	129
0602	UNITS NOT EQUAL TO TEETH BILLED	16
0606	MISSING OR INVALID PAYER DATE	125
0643	INVALID OTHER COVERAGE CODE	45
0675	ADJ - RECIPIENT ID NOT SUBMITTED	16
0676	ADJ - PROVIDER ID NOT SUBMITTED	16
0677	ADJ - ORIGINAL ICN NOT FOUND	16
0678	ADJ - ORIGINAL ICN NOT SUBMITTED	16

EOB Code	EOB Description	Adjustment Reason Code
0679	ADJ - REQUEST RECIPIENT ID NOT FOUND	16
0680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL	16
0681	ADJ - ORIGINAL ICN NOT FOUND	16
0682	ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED	16
0683	ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS	16
0684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL	16
0685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS	16
0800	DETAIL RATE NOT NUMERIC	125
0801	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT	125
0802	MISSING OR INVALID PRESCRIBER ID QUALIFIER	16
0803	DATED EXCEED SOBRA/QMB ELIGIBILITY	141
0804	BILLING PROVIDER CANNOT BE PRESCRIBER	52
0805	NONCOVERED CHARGE IS NOT NUMERIC	125
0806	MEDICARE PAID AMOUNT MISSING OR INVALID	125
0807	INVALID TPL ADJUDICATION DATE	16
0808	TPL ADJUDUCATION DATE CANNOT BE A FUTURE DATE	16
0809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS	16
0810	INVALID DEDUCTIBLE AMT - SKILLED NURSING FACILITY	125
0811	HEADER FROM DATE OF SERVICE > ICN DATE	125
0812	ADMIT DATE IS GREATER THAN ICN DATE	125
0813	MEDICARE PAID DATE > ICN DATE	16
0814	DETAIL TO DATE OF SERVICE > ICN DATE	125
0815	SURGICAL ICD9 REQUIRES OPERATING PHYSICIAN	125
0816	COINSURANCE DAYS NOT NUMERIC	2
0817	INVALID COINSURANCE DAYS	2
0818	LIFETIME RESERVE DAYS NOT NUMERIC	125
0819	LIFETIME RESERVE DAYS > MAX ALLOWED	125
0820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR	125
0821	NON-COVERED DAYS MISSING OR NOT NUMERIC	125
0822	SURGICAL REVENUE CODE REQUIRES ICD9 SURGERY CODE	125
0823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID	125
0824	UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION	B5
0825	MEDICARE ALLOWED AMOUNT MISSING OR INVALID	125
0826	TYPE OF BILL INVALID FOR CLAIM TYPE	16
0827	NON COVERED AMOUNT IS GREATER THAN COVERED AMOUNT	125
0829	DAYS SUPPLY > 3 FOR EMERGENCY PHARMACY CLAIM	57
0830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW	125
0831	MEDICARE HDR PAID AMNT NOT EQUAL SUM OF DTL PAID	125
0832	OTHER PAYER AMOUNT PAID QUALIFIER INVALID	16
0833	CO-INSURANCE AMOUNT DOES NOT BALANCE	16
0835	MEDICARE DATA NOT FOUND - FORMAT ERROR	16

EOB Code	EOB Description	Adjustment Reason Code
0900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	16
0901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE	16
0902	PROCEDURE CODE GROUP NOT FOUND	16
0903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T	16
0904	GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE	16
0905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL	16
0906	GROUP NUMBER NOT FOUND IN ICD-9 GROUP TABLE	16
0907	GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE	16
0909	GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE	16
0910	BENEFIT PLAN GROUP NOT FOUND	16
0911	INTERNAL PROCESSING ERROR - CONTACT EDS	16
0912	INTERNAL ERROR-DOLLAR DISTRIBUTION	16
0913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE	16
0914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE	16
0915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE	16
0916	GROUP NOT FOUND IN PROVIDER GROUP TABLE	16
0917	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE	16
0918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR	16
0919	GROUP NUMBER NOT FOUND IN AID CODE TABLE	16
0920	DRUG THERAPEUTIC CLASS GROUP NOT FOUND	16
0921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE	16
0922	TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE	16
0923	RULE OVERLAP IDENTIFIED	16
1000	NO PAY-TO PROVIDER RECORD	16
1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE	B7
1002	PERFORMING PROV NOT ELIGIBLE FOR DOS	52
1003	PROVIDER INELIGIBLE ON DATE OF SERVICE	52
1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE	16
1010	PERFORMING PROVIDER NOT IN BILLING GROUP	38
1018	CLINIC RATE NOT ON FILE FOR HOSPITAL	16
1020	ATTENDING PHYSICIAN ID NOT ON FILE	52
1021	OTHER-1 (OPERATING) PROVIDER ID NOT ON FILE - HDR	52
1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV	45
1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE	52
1032	PROVIDER TYPE - CLAIM INPUT CONFLICT	62
1048	PERFORMING PROVIDER ENROLLMENT STATUS INVALID	52
1049	BILLING PROVIDER ENROLLMENT STATUS INVALID	B7
1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE	16

EOB Code	EOB Description	Adjustment Reason Code
	(HDR)	
1065	PROVIDER NAME MISMATCH	125
1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER	125
1804	VERFIY PERFORMING PROVIDER NOT GROUP PROVIDER	125
1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS	125
1806	EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS UNDER	6
1807	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE	16
1808	REFERRING PROVIDER IS MISSING OR NOT ON FILE	52
1809	REFERRING PROVIDER-NO SCREENING SPECIALTY FOR DOS	52
1812	RECIPIENT / ADMIT AGE GREATER THAN 21	6
1813	PROVIDER SUSPENDED FOR OUTSTANDING CREDIT BALANCE	52
1814	BILLING PROVIDER NOT VALID FOR DATES OF SERVICE	B7
1816	MATERNITY CARE MUST BE PERFORMED BY DISTRICT PROV	109
1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS	4
1818	WAIVER PROVIDER MISMATCH	B7
1819	INVALID POS FOR FQHC PROVIDER	5
1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL	38
1821	MEDICAL LOCKIN - RECIPIENT LOCKED IN TO OTHER PROVIDER	
1822	MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES	
1823	WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES	
1824	LTC ASSIGNMENT DATES OVERLAP CLAIM DATES	
1825	COBA DENIAL - DO NOT CROSSOVER	16
1900	TAXONOMY IS INVALID BILLING PROVIDER	45
1901	TAXONOMY IS INVALID PREFORMING PROVIDER	45
1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	45
1907	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	45
1912	TAXONOMY IS MISSING: BILLING PROVIDER	45
1913	TAXONOMY IS MISSING: PERFORMING PROVIDER	45
1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	45
1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER	45
1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	45
1927	NPI REQUIRED HEALTHCARE=Y BILLING PROV	45
1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV	45
1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV	45
1934	DTL NPI REQUIRED HEALTHCARE=Y PREMING PROV	45
1936	INVALID BILLING PROVIDER SPECIFIED	47
1937	INVALID PREFORMING PROVIDER SPECIFIED	47

EOB Code	EOB Description	Adjustment Reason Code
1938	INVALID REFERRING PROVIDER SPECIFIED	47
1939	INVALID FACILITY PROVIDER SPECIFIED	47
1940	INVALID RENDERING PROVIDER SPECIFIED	47
1941	INVALID OTHER PROVIDER SPECIFIED	47
1942	INVALID DTL OTHER PROVIDER SPECIFIED	47
1943	INVALID DTL PREFORMING PROVIDER SPECIFIED	47
1944	INVALID DTL REFERRING PROVIDER SPECIFIED	47
1945	MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER	47
1946	MULT SAK PROV LOCS FOR PREFORMING PROV SPEC	47
1949	MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER	47
1952	MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER	47
1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)	16
1961	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)	16
1995	MMIS FACILITY PROVIDER ID NOT ENROLLED	52
1996	THE RENDERING PROVIDER IS NOT ENROLLED IN THE MEDICAID PROGRAM.	B7
1999	PROVIDER ID IS INVALID, IS NOT ON FILE OR NAME/NUMBER DISAGREE.	92
2001	RECIPIENT IS NOT ON ELIGIBILITY FILE	30
2002	RECIPIENT NOT ELIGIBLE FOR HEADER DATE OF SERVICE	30
2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	141
2009	RECIPIENT INELIGIBLE ON DATE OF SERVICE	30
2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	100
2054	UNABLE TO DETERMINE FUND CODE - DETAIL	16
2057	RECIPIENT PARTIALLY ELIGIBILE - HEADER	B5
2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF SERVICES	141
2500	RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT)	109
2501	RECIPIEINT COVERED BY MEDICARE A (WITH ATTACHMENT	109
2502	RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT)	109
2503	RECIPIENT COVERED BY MEDICARE B (WITH ATTACHMENT)	109
2504	FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER	129
2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT)	129
2507	THIS PATIENT HAS TWO COVERAGE TYPES	22
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	129
2550	RECIPIENT ENROLLED IN MEDICARE ADVANTAGE PLAN	109
2590	SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE	16
2591	SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE	16

EOB Code	EOB Description	Adjustment Reason Code
2603	RECIPIENT LOCK-IN TO SPECIFIC PRESCRIBING PROVIDER	52
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	17
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	17
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	17
2804	DETAILS COVERED BY MORE THAN ONE PLAN CODE	141
2805	DOS PRIOR TO DOB	14
2806	PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX	6
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	
3000	PCS PRIOR AUTHORIZATION UNITS USED	62
3001	PA NOT FOUND ON DATABASE	62
3002	NDC REQUIRES PA	62
3003	PROCEDURE REQUIRES PRIOR AUTHORIZATION	62
3006	PRIOR AUTH UNITS/AMOUNTS USED	62
3019	PA CUTBACK PERFORMED	92
3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH	6
3101	ONLINE PA DENIED BY HID, NDC REQUIRES PA	6
3102	ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM	6
3103	ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS	6
3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES	16
3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH	B5
3301	BILL EMERGENCY PROCEDURE/REVENUE TOGETHER	
3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID	B5
3303	MEDICARE PAID AMOUNT EQUAL 100%	42
3304	NON-COVERED SVC FOR RECIPIENT < 6 MONTHS OLD	6
3305	NO BASE VALUE FOR ANESTHESIA	
3306	HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT	125
3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT	B5
3308	PROCEDURE CODE/MODIFIER NOT ON RATE FILE	
3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION	16
3310	DISPENSING FEE NOT LOCATED	16
3311	REFILL NUMBER EXCEEDS MAXIMUM ALLOWED	B5
3312	DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY	62

EOB Code	EOB Description	Adjustment Reason Code
3313	NDC DRUG, PRODUCT IS NOT PREFERRED	62
3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP	B5
3315	NURSERY DAYS EXCEED LIMIT	16
3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDI	16
3317	CLAIM QUANTITY EXCEEDS NDC MAX UNITS	
3599	MANUAL PRICING REQUIRED	101
3800	SERVICE COVERAGE HAS NOT BEEN DETERMINED	16
3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION	16
3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16
4001	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION	16
4002	BPA-RP-NDC - NO COVERAGE	16
4004	NDC IS NOT ON FILE	96
4013	PROCEDURE CODE IS NO LONGER VALID	96
4014	NO PRICING SEGMENT IS ON FILE.	133
4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16
4021	BPA-RP-PROC - NO COVERAGE	16
4023	BPA-RP-NDC - GENDER RESTRICTION	16
4025	BPA-RP-NDC - AGE RESTRICTION	16
4026	BPA-RP-NDC - MAX UNIT RESTRICTION	16
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE	92
4028	BPA-RP-DIAG - GENDER RESTRICTION	16
4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION	16
4030	BPA-RP-DIAG - AGE RESTRICTION	16
4031	BPA-PC-DIAG - GENDER RESTRICTION	16
4032	PROCEDURE CODE IS MISSING/NOT ON FILE	96
4034	BPA-RP-PROC - AGE RESTRICTION	16
4035	BPA-RP-PROC - GENDER RESTRICTION	16
4036	BPA-RP-PROC - PLACE OF SERVICE RESTRICTION	16
4040	PRIMARY DIAGNOSIS CODE NOT ON FILE	47
4041	SECONDARY DIAGNOSIS CODE NOT ON FILE	47
4042	THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE	47
4043	FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE	47
4044	BPA-RR-DIAG - NO RULE FOR ASSOC AGE	16
4045	BPA-RR - NO RULE FOR BENEFIT PLAN	16
4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	96
4047	FIFTH DIAGNOSIS CODE NOT ON FILE	47
4048	SIXTH DIAGNOSIS CODE NOT ON FILE	47
4049	SEVENTH DIAGNOSIS CODE NOT ON FILE	47
4050	EIGHTH DIAGNOSIS CODE NOT ON FILE	47
4051	NINTH DIAGNOSIS CODE NOT ON FILE	47
4052	ADMITTING DIAGNOSIS CODE NOT ON FILE	47
4059	REVENUE CODE NOT ON FILE	16
4061	BPA-RR - NO RULE FOR CLAIM TYPE	16

EOB Code	EOB Description	Adjustment Reason Code
4062	BPA-RR - NO RULE FOR COND CODE	16
4064	BPA-RP-ICD9 - GENDER RESTRICTION	16
4068	BPA-RR - NO RULE CURR BILL PROV CONTRACT	16
4070	BPA-RR-PROC - MODIFIER RESTRICTION	16
4072	BPA-RR-DRG - NO RULE FOR ADMIT OR HDR DIAGNOSIS	16
4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION	16
4075	BPA-RP-ICD9 - FAMILY PLANNING IND RESTRICTION	16
4076	BPA-RP-NDC - FAMILY PLANNING IND RESTRICTION	16
4077	NON-COVERED REVENUE CODE	92
4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION	16
4094	BPA-PC-REV - PROV COUNTY RESTRICTION	16
4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION	16
4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION	16
4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION	16
4112	BPA-PC-ICD9 - FAMILY PLANNING IND RESTRICTION	16
4117	BPA-PC-DRUG - FAMILY PLANNING IND RESTRICTION	16
4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION	16
4120	ORAL CAVITY DESIGNATION CODE INVALID	16
4127	CANNOT PRIORITIZE RECIPIENT'S PROGRAMS	133
4130	PAYER HIERARCHY NOT FOUND	63
4131	NO BENEFIT PLANS ASSOCIATED TO PAYER	63
4136	BPA-RP-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16
4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION	16
4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16
4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16
4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16
4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16
4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16
4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16
4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16
4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16
4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION	16
4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION	16
4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION	16
4159	BPA-PC-ICD9 - CURR PROV CONTRACT RESTRICTION	16
4160	BPA-PC-DRUG - CURR PROV CONTRACT RESTRICTION	16
4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION	16
4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION	16
4164	INACTIVE DRUG	6

EOB Code	EOB Description	Adjustment Reason Code
4166	BPA-RR-DRUG - NO RULE FOR BENEFIT PLAN	16
4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN	16
4177	BPA-PC-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16
4192	BPA-RP-DRG - OTHER DTL DIAG RESTRICTION	16
4200	CLAIM PRICED AT ZERO	92
4203	DENIAL MODIFIER SUBMITTED ON CLAIM	B7
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	100
4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD	45
4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION	16
4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE	96
4212	BILLING OUT OF CLIA CERTIFICATE TYPE	5
4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL	16
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4224	BPA-RP-PROC - QUANTITY RESTRICTION	16
4225	INVALID INPATIENT REVENUE CODE	16
4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION	16
4227	BPA-RP-REV - NO COVERAGE	16
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4231	BPA-PC-DRUG - MAX UNIT RESTRICTION	16
4240	THIS PROCEDURE MUST BE BILLED SEPARATELY EACH DATE	16
4244	BPA-RP-DIAG - NO COVERAGE	16
4245	FOURTH MODIFIER INVALID FOR DATE OF SERVICE	4
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	45
4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF	16
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	16
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	16
4254	BPA-RP-REV - AGE RESTRICTION	16
4256	BPA-RP-PROC - MODIFIER RESTRICTION	16
4257	BPA-PC-PROC - MODIFIER RESTRICTION	16
4258	BPA-PC-DRG - OCCURRENCE CODE RESTRICTION	16
4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION	16
4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION	16
4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION	16
4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION	16
4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION	45
4316	BPA-PC -ANY DTL DIAG RESTRICTION	16
4317	BPA-PC-ICD9 - ADMIT DIAG RESTRICTION	16
4318	BPA-PC-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16

EOB Code	EOB Description	Adjustment Reason Code
4319	BPA-PC-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16
4320	BPA-PC-REV - ADMIT DIAG RESTRICTION	16
4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION	16
4361	BPA - DIAGNOSIS RESTRICTION	16
4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION	16
4364	BPA-PC-ICD9 - TYPE OF BILL RESTRICTION	16
4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION	16
4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION	16
4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION	16
4374	BPA-RP-REV - CLAIM TYPE RESTRICTION	16
4376	BPA-RP-ICD9 - CLAIM TYPE RESTRICTION	16
4500	BPA-RR-NDC - ALGI RESTRICTION	16
4501	BPA-RR-NDC - NO RULE FOR DISP AS WRITTEN IND	16
4502	BPA-RP-PROC - EPSDT REFERRAL RESTRICTION	16
4503	BPA-PC-PROC - EPSDT REFERRAL RESTRICTION	16
4504	BPA-RP-NDC - ALGI RESTRICTION	16
4505	BPA-RR-PROC - NO RULE FOR URBAN/RURAL IND	16
4506	BPA-PC-DIAG - PERF PROV ALL PT/PS RESTRICTION	16
4508	BPA-PC-PROC - PERF PROV ALL PT/PS RESTRICTION	16
4509	BPA-PC-REV - PERF PROV ALL PT/PS RESTRICTION	16
4511	BPA-RP-DIAG - PERF PROV ALL PT/PS RESTRICTION	16
4514	BPA-RP-PROC - PERF PROV ALL PT/PS RESTRICTION	16
4515	BPA-RP-REV - PERF PROV ALL PT/PS RESTRICTION	16
4516	BPA-PC-DIAG - BILL PROV ALL PT/PS RESTRICTION	16
4517	BPA-PC-DRUG - BILL PROV ALL PT/PS RESTRICTION	16
4518	BPA-PC-ICD9 - BILL PROV ALL PT/PS RESTRICTION	16
4519	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION	16
4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION	16
4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION	16
4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION	16
4523	BPA-RP-ICD9 - BILL PROV ALL PT/PS RESTRICTION	16
4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION	16
4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION	16
4526	BPA-PC-PROC - PROV COUNTY RESTRICTION	16
4527	BPA-PC-DRUG - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4529	BPA-RP-REV - PROV COUNTY RESTRICTION	16
4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION	16
4532	BPA-RR-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16
4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION	16
4534	BPA-RP-DRG - EMERGENCY DIAGNOSIS RESTRICTION	16
4535	BPA-RP-ICD9 - EMERGENCY DIAGNOSIS RESTRICTION	16
4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16
4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION	16
4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16
4540	BPA-PC-PROC - MIN UNIT RESTRICTION	16

EOB Code	EOB Description	Adjustment Reason Code
4542	BPA-RP-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16
4548	BPA-PC-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16
4554	BPA-RR-DRG - REFER PROV PRIMARY PT/PS RESTRICTION	16
4559	BPA-RP-DRG - SECONDARY HDR DIAG RESTRICTION	16
4560	BPA-RP-ICD9 - SECONDARY HDR DIAG RESTRICTION	16
4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION	16
4562	BPA-RP-REV - GENDER RESTRICTION	16
4563	BPA-RR - NO RULE CURR PERF PROV CONTRACT	16
4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION	16
4565	BPA-RR-ICD9 - HDR SECONDARY DIAG RESTRICTION	16
4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION	16
4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP	16
4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP	16
4711	BPA-PC-DIAG - AGE RESTRICTION	16
4713	BPA-PC-DRUG - AGE RESTRICTION	16
4714	BPA-PC-PROC - AGE RESTRICTION	16
4715	BPA-PC-REV - AGE RESTRICTION	16
4716	BPA-PC-ICD9 - AGE RESTRICTION	16
4723	BPA-RP-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4724	BPA-RP-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16
4726	BPA-RP-ICD9 - ADMIT DIAG RESTRICTION	16
4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION	16
4732	BPA-RP-REV - ADMIT DIAG RESTRICTION	16
4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION	16
4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION	16
4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16
4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION	16
4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION	16
4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION	16
4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION	16
4747	BPA-PC-ICD9 - HDR SECONDARY DIAG RESTRICTION	16
4748	BPA-PC-REV - HDR SECONDARY DIAG RESTRICTION	16
4751	BPA-PC-REV - TYPE OF BILL RESTRICTION	16
4755	BPA-PC-PROC - CURRENT BENEFIT PLAN RESTRICTION	16
4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION	16
4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION	16
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4762	BPA-PC-ICD9 - PLACE OF SERVICE RESTRICTION	16
4765	BPA-RP-ICD9 - NO COVERAGE	16
4766	BPA-RP-ICD9 - AGE RESTRICTION	16
4767	BPA-RP-ICD9 - PLACE OF SERVICE RESTRICTION	16

EOB Code	EOB Description	Adjustment Reason Code
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4775	BPA-PC-DRUG - BILL PROV PRIMARY PT/PS RESTRICTION	16
4776	BPA-PC-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION	16
4801	BPA-PC-PROC - NO CONTRACT	16
4802	BPA-PC-DIAG - NO CONTRACT	16
4803	BPA-PC-NDC - NO CONTRACT	16
4804	BPA-PC-REV - NO CONTRACT	16
4806	BPA-PC-ICD9 - NO CONTRACT	16
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
9998	CLAIM WAS PRICED IN ACCORDANCE WITH MEDICAID POLICY	
4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION	16
4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION	16
4831	BPA-RR - NO REIMB RULE	16
4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION	16
4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION	16
4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION	16
4873	BPA-PC-DRUG - CLAIM TYPE RESTRICTION	16
4874	BPA-PC-REV - CLAIM TYPE RESTRICTION	16
4876	BPA-PC-ICD9 - CLAIM TYPE RESTRICTION	16
4900	BPA-RP-DIAG - BENE PLAN RESTRICTION	16
4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION	16
4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION	16
4904	BPA-RP-DRG - OTHER HDR DIAGNOSIS RESTRICTION	16
4905	BPA-RP-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16
4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16
4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION	16
4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION	16
4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION	16
4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR	16
4917	BPA-PC-DRG - OTHER HDR DIAGNOSIS RESTRICTION	16
4923	BPA-PC-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16
4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION	16
4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION	16
4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION	16
4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16
4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION	16
4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION	16
4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION	16
4940	BPA-RP-ICD9 - BENE PLAN RESTRICTION	16
4941	BPA-RP-ICD9 - CONDITION CODE RESTRICTION	16
4942	BPA-RP-ICD9 - OCCURRENCE CODE RESTRICTION	16

EOB Code	EOB Description	Adjustment Reason Code
4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION	16
4944	BPA-PC-ICD9 - GENDER RESTRICTION	16
4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION	16
4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION	16
4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION	16
4950	BPA-PC-ICD9 - BENEFIT PLAN RESTRICTION	16
4951	BPA-PC-ICD9 - CONDITION CODE RESTRICTION	16
4952	BPA-PC-ICD9 - OCCURRENCE CODE RESTRICTION	16
4953	BPA-RR-DRG - OTHER DTL DIAG RESTRICTION	16
4960	BPA-RP-NDC - BENE PLAN RESTRICTION	16
4961	BPA-RP-PROC - PROV COUNTY RESTRICTION	16
4962	BPA-PC-DRUG - GENDER RESTRICTION	16
4963	BPA-PC-PROC - GENDER RESTRICTION	16
4964	BPA-PC-REV - GENDER RESTRICTION	16
4965	BPA-PC-DRUG - BENEFIT PLAN RESTRICTION	16
4966	BPA-RR - DIAGNOSIS RESTRICTION	16
4970	BPA-RP-REV - BENE PLAN RESTRICTION	16
4971	BPA-RP-REV - CONDITION CODE RESTRICTION	16
4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION	16
4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION	16
4975	BPA-PC-REV - NO RULE FOR BENEFIT PLAN	16
4976	BPA-PC-REV - CONDITION CODE RESTRICTION	16
4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION	16
4980	BPA-RP-PROC - BENE PLAN RESTRICTION	16
4981	BPA-RP-PROC - CONDITION CODE RESTRICTION	16
4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION	16
4983	BPA-RR-DRG - OTHER HDR DIAGNOSIS RESTRICTION	16
4990	BPA-PC-PROC - BENEFIT PLAN RESTRICTION	16
4991	BPA-PC-PROC - CONDITION CODE RESTRICTION	16
4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION	16
4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION	16
4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICARE PART A OR B, THE RECIPIENT IS ELIGIBLE FOR MEDICARE PART D DRUG COVERAGE AND MEDICAID WILL ONLY PAY FOR DRUGS SPECIFICALLY EXCLUDED FROM MEDICARE PART D.	46
5000	OUR RECORDS SHOW THIS SERVICE HAS ALREADY BEEN PAID FOR THE DATE OF SERVICE BILLED.	18
5001	OUR RECORDS SHOW THIS SERVICE FOR THE DATE OF SERVICE BILLED IS A DUPLICATE.	18
5010	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18
5012	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18
5013	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18

EOB Code	EOB Description	Adjustment Reason Code
5014	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18
5015	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18
5016	OUR RECORDS SHOW THIS SERVICE FOR THE DATE(S) OF SERVICE BILLED IS A DUPLICATE.	18
5020	SUSPECT DUPLICATE OF ANOTHER PHARMACY CLAIM.	18
5021	EXACT DUPLICATE OF ANOTHER PHARMACY CLAIM.	18
5022	DUPLICATE RX CODE FOR SAME DATE OF SERVICE.	18
5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR VACCINE REPLACEMENT	97
5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR VACCINE REPLACEMENT	97
5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCEDURE	97
5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCEDURE	97
5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	97
5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	97
5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	97
5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	97
5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	97
5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	97
5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLED ON THE SAME DAY	B5
5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLED ON THE SAME DAY	B5
5212	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518567	B5
5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518567	B5
5214	PROCEDURE CODE NOT ALLOWED ON THE SAME DAY	B5
5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97
5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97
5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON THE SAME DAY AS A PROCEDURE FOR CATHETHER PLACEMENT.	B5

EOB Code	EOB Description	Adjustment Reason Code
5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON THE SAME DAY AS A PROCEDURE FOR CATHETHER PLACEMENT.	B5
5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	B5
5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	B5
5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED	119
5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS OR ON SAME DAY OF EACH OTHER.	
5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS OR ON SAME DAY OF EACH OTHER.	
5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97
5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97
5260	BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AID	119
5261	BATTERIES MAY NOT BE PURCAHSED WITHIN 60 (SIXTY) DAYS OF PURCHASE OF HEARING AID	119
5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE SAME OR DIFFERENT PROVIDER	B5
5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMBER AS 99241-99245 AND 99281-99285ER AS 99241-99245 AND 99281-99286ER AS 99241-99245 AND 99281-99287	B5
5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY	B5
5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5

EOB Code	EOB Description	Adjustment Reason Code
5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5
5314	PULP THERAPY COMBINATION NOT ALLOWED	B5
5315	PULP THERAPY COMBINATION NOT ALLOWED	B5
5316	PULP THERAPY COMBINATION NOT ALLOWED	B5
5317	PULP THERAPY COMBINATION NOT ALLOWED	B5
5318	PULP THERAPY COMBINATION NOT ALLOWED	B5
5319	PULP THERAPY COMBINATION NOT ALLOWED	B5
5320	PULP THERAPY COMBINATION NOT ALLOWED	B5
5321	PULP THERAPY COMBINATION NOT ALLOWED	B5
5322	PULP THERAPY COMBINATION NOT ALLOWED	B5
5323	PULP THERAPY COMBINATION NOT ALLOWED	B5
5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE MUST BE BILLED.	B15
5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE MUST BE BILLED.	B15
5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5
5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5
5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5
5329	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5
5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5
5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5
5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97
5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97

EOB Code	EOB Description	Adjustment Reason Code
5334	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR OTHER EMERGECNY PROCEDURES ON THE SAME DAY.	97
5335	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR OTHER EMERGECNY PROCEDURES ON THE SAME DAY.	97
5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.	119
5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.	119
5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.	107
5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.	B5
5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125
5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125
5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5
5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5
5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5
5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5
5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICES ON THE SAME DAY	B5
5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVICES ON THE SAME DAY	B5
5404	EPSDT VISIT HAS BEEN PAID FOR THIS RECIPIENT FOR THE SAME DATE OF SERVICE.	18
5410	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE.	119
5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVICE.	119
5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5
5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5
5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5
5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5
5416	VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM	97
5417	VISUAL FIELDS/TONOMETRY IS COVERED IN THE COMPLETE EYE EXAM	97

EOB Code	EOB Description	Adjustment Reason Code
5430	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC OR HOME VISIT.	B5
5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC OR HOME VISIT.	B5
5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5
5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5
5434	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	119
5436	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5
5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5
5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5
5439	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLEDON THE SAME DAY.	B5
5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5
5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5
5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME CLAIM.	B5
5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97
5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97
5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).	97
5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	
5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	
5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97
5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97
5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5
5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5
5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5

EOB Code	EOB Description	Adjustment Reason Code
5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5
5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5
5480	COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5481	COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5482	COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5483	COMPONENETS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.	125
5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE	125
5488	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	18
5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	18
5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5
5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5
5506	PROVIDER MAY NOT BILL FOR NEWBORN RESUSCITATION UNLESS LIFE THREATENING	125
5507	PROVIDER MAY NOT BILL FOR NEWBORN RESUSCITATION UNLESS LIFE THREATENING	125
5508	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID ALLOWED	B5
5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID ALLOWED	B5
5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY	119
5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.	B14

EOB Code	EOB Description	Adjustment Reason Code
5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5
5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5
5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97
5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97
5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB CARE	97
5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB CARE	97
5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BILLED SEPARATELY WITH A DELIVERY PROCEDURE CODE	97
5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BILLED SEPARATELY WITH A DELIVERY PROCEDURE CODE	97
5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59
5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59
5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB PROCEDURE	97
5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB PROCEDURE	97
5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DELIVERY	97
5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DELIVERY	97
5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5
5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5
5602	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5
5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97
5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97
5606	PAYMENT MADE FOR SIMILAR PROCEDURE	97
5607	PAYMENT MADE FOR SIMILAR PROCEDURE	97
5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT.	97

EOB Code	EOB Description	Adjustment Reason Code
5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIPIENT.	97
5610	PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95120 - 95134.	B5
5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.	B5
5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95135-95170, 95135-95171,95135-95172	B5
5613	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES 95135-95170, 95135-95171, 95135-95172	B5
5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5
5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5
5616	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5
5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5
5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAME DAY	B5
5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAME DAY	B5
5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLEDTOGETHER.	B5
5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5
5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5
5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5
5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14
5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14
5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5
5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5
5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOTHER NUMBER FOR THIS PROVIDER	B13

EOB Code	EOB Description	Adjustment Reason Code
5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOTHER NUMBER FOR THIS PROVIDER	B13
5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97
5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97
5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER RELATED SURGERY	97
5633	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SURGERY ON THE SAME DAY	97
5634	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME DAY	B14
5635	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME DAY	B14
5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY PROCEDURE CODE	97
5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY PROCEDURE CODE	97
5638	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97
5639	HOSPITAL ADMISSION/VISITS MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97
5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14
5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14
5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL ABORTION COST AND ARE NOT REIMBURSABLE SEPARATELY	97
5643	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL ABORTION COST AND ARE NOT REIMBURSABLE SEPARATELY	97
5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14
5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14
5646	POST-OPERATIVE PHYSICAIN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITHIN 62 DAYS OF SURGERY	97
5647	POST-OPERATIVE PHYSICAIN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITHIN 62 DAYS OF SURGERY	97
5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)	B5

EOB Code	EOB Description	Adjustment Reason Code
5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY	B14
5652	ONLY ONE INITIAL NICU PROCEDURE MAY BE BILLED PER HOSPITAL STAY.	119
5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97
5658	A CARDIOLOGIST OR A RADIOLOGIST CANNOT BILL THIS PROCEDURE CODE ON THE SAME DAY	18
5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY	B14
5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITAL CARE.	B5
5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5
5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5
5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5
5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B7
5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B7
5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5
5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5
5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPENT	B5
5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPENT	B5
5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5
5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5
5724	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5725	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5

EOB Code	EOB Description	Adjustment Reason Code
5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5
5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5
5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96
5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96
5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5
5733	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5
5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5
5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/OFFICE VISITS ON THE SAME DAY	B5
5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5
5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5
5740	INDIVIDUAL THERAPY AND GROUP THERAPY MAY NOT BE BILLED ON THE SAME DAY.	B14
5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5
5751	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5
5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5
5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5
5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT	18
5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT	18
5760	ESWL PRICING	42
5770	INDEPENDENT RURAL HEALTH CLINICS CANNOT BE PAID FOR MORE THAN ONE SERVICE PER DAY.	119
5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA	119
5791	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5
5792	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119
5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR THE SAME DOS.	18

EOB Code	EOB Description	Adjustment Reason Code
5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANION CARE NOT ALLOWED FOR THE SAME DOS.	18
5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME DAY	B5
5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME DAY	B5
5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.	18
5811	HEARING AND VISION SCREENING REQUIRE EP MODIFIER.	B18
5812	POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLOW-UP CARE CANNOT BE PAID UNTIL THE SURGEON HAS BEEN PAID. CONTACT THE SURGEON	B5
5813	POST-CATARACT FOLLOW-UP CARE HAS BEEN PAID TO THE SURGEON ORPOST-CATARACT FOLLOW-UP CARE CANNOT BE PAID UNTIL THE SURGEON HAS BEEN PAID. CONTACT THE SURGEON	B5
5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.	97
5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LIMITED TO ONCE PER YEAR	119
5816	HIV CODES MUST BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.	B5
5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5
5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.	B5
5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.	B5
5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOOTH NUMBER.	B5
5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE CODE IS NOT COVERED.	B5
5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE CODE IS NOT COVERED.	B5
6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MONTH.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119

EOB Code	EOB Description	Adjustment Reason Code
6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.	119
6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.	119
6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119
6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT	119
6041		
6042		
6043		
6044	EMERGENCY ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.	119
6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.	119
6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS	119
6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS	119
6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS	119
6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.	119
6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS	119
6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS	119
6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION	15
6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.	119
6100	PROCEDURE IS LIMITED TO SIXTY (60) PER CALENDAR MONTH.	119

EOB Code	EOB Description	Adjustment Reason Code
6101	PROCEDURE IS LIMITED TO FIFTEEN (15) PER CALENDAR MONTH.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6102	PROCEDURE IS LIMITED TO ONE (1) EVERY FIVE YEARS	119
6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6104	PROCEDURE CODE IS LIMITED TO ONE-HUNDRED (100) PER MONTH.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6105	PROCEDURE IS LIMITED TO 60 (SIXTY) TIMES PER CALENDAR MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6107	PROCEDURE CODE IS LIMITED TO 40 (FORTY) PER CALENDAR MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6108	PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS	119
6109	PROCEDURE CODE IS LIMTED TO 100 PER MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6113	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6114	PROCEDURE IS LIMITED TO TWO PER YEAR.	119
6115	MEDICAL SUPPLIES LIMIT IS $1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119

EOB Code	EOB Description	Adjustment Reason Code
6116	PROCEDURE IS LIMITED TO ONE (1) EVERY FOUR CALENDAR YEARS.	119
6117	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6118	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6119	PROCEDURE IS LIMITED TO 1 (ONE) EVERY TWO YEARS	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.	119
6121	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6122	LEG BAGS ARE LIMITED TO TWO PER MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6123	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6124	PROCEDURE IS LIMITED TO ONE (1) EVERY THREE YEARS.	119
6125	CATHETERS, CATHETER TRAYS, AND DRAINAGE BAGS ARE LIMITED TO TWO PER MONTH.	119
6126	PROCEDURE IS LIMITED TO ONE HUNDRED TWENTY (120) PER CALENDAR MONTH.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6150	VISION AND HEARING SCREENING ONE PER YEAR	119
6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME	119
6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6154	MAXIMUN UNIT LIMIT HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.	119
6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119

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6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED	119
6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119
6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED	119
6200	THIS PROCEDURE IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119
6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.	119
6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME	119
6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR	119
6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977 CANNOT BE BILLED WITHIN 60 MONTHS OF INSERTION	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE ONLY.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.	119
6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6230	MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE SAME DATE OF SERVICE.	B5
6231	MORE THAN ONE DENTAL ENCOUNTER (D9430)CANNOT BE PAID ON THE SAME DATE OF SERVICE.	B14
6240	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6241	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6242	HBO LIMIT HAS BEEN EXCEEDED	119

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6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6243	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6244	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6245	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6246	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6247	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6248	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6249	HBO LIMIT HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6260	NUMBER OF HOME HEALTH VISITS EXCEED LIMIT	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6280	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR	119
6281	OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6282	INPATIENT DAYS HAVE BEEN EXEEDED FOR THIS CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6283	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5
6290	MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY	B5
6291	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119
6300	THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS.	119
6301	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED W ITHIN SIX MONTHS	119
6302	MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS.	B5

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6303	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS.	B5
6310	THE QUANTITY DISPENSED EXCEEDS THE MAXIMUM QUANTITY ALLOWED FOR THE DRUG CODE PRESCRIBED.	119
6311	QTY DISPENSED EXCEEDS MAX QTY BASED ON PA	62
6312	MONTHLY SCRIPT LIMIT EXCEEDED	119
6313	MONTHLY SCRIPT LIMIT EXCEEDED - BRANDED DRUG	
6314	MONTHLY SCRIPT LIMIT EXCEEDED	
6400	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119
6401	OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUIRE PRIOR AUTHORIZATION.	119
6402	SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR	119
6403	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR.	119
6404	PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER	119
6405	PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6406	NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE	119
6407	THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIPIENT IN A THREE YEAR PERIOD.	119
6408	PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT	B14
6409	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6410	PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6411	INITIAL CRITICAL CARE LIMITED TO ONE PER DAY	119
6412	ER AND CRITICAL CARE CODE ONE PER CLAIM.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6413	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	
6510	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119

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6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6511	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6512	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6513	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6514	THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6515	THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR	119
6516	THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6517	THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6518	PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6519	PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6520	PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6521	THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6522	THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6523	BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6524	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119

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6525	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6526	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6527	BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6528	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6529	PROCEDURE IS LIMITED TO 260 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6530	PROCEDURE IS LIMITED TO 8 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6531	PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6532	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6533	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6534	PROCEDURE IS LIMITED TO 2016 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6535	PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6536	PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6537	PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6538	YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119

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6539	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6540	PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF SERVICE 21" (INPATIENT) "	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6541	DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR	119
6542	PROCEDURE IS LIMITED TO 4160 UNITS A YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6610	DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER RECIPIENT.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6611	PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6612	PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH.	119
6613	PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6630	THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH.	119
6640	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6641	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6642	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6643	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6644	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119

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6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6645	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	B5
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	B5
6646	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	18
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	18
6647	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6650	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THIS CONTRACT YEAR	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6651	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119
6652	UNITS BILLED FOR PROCEDURE CODE EXCEED MAXIMUM UNITS ALLOWED	119
6653	PROCEDURE LIMITED TO 1080 HOURS,PER WAIVER YEAR OCTOBER 1 - SEPTEMBER 30.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6670	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119
6671	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS RECIPIENT.	18
6672	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIENT	18
6673	PROCEDURE IS LIMITED TO ONE (1) EVERY TWO YEARS.	119
6674	CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL.	133
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	133
6677	PROCEDURE CODE CANNOT BE BILLED MORE THAN SIX(6) TIMES WITH THE SAME MODIFIER.	18
6690	REVENUE CODE 183 IS LIMITED TO 6 DAYS EACH CALENDAR QUARTER.	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
6691	REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDAR MONTH	119
6999	UNITS ON THIS CLAIM HAVE BEEN SYSTEMATICALLY REDUCED TO MEET THE BENEFIT LIMIT	119
7000	CLAIM FAILED A PRODUR ALERT	133

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7002	CLAIM DENIED FOR PRODUR REASONS	6
7003	PRODUR ALERT REQUIRES PA FOR OVERRIDE	6
7004	NON-OVERRIDEABLE PRODUR ALERT	6
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8204	PRIMARY INSURANCE PAYMENT RECEIVED	63
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